NEW PATIENT HISTORY

To facilitate our getting to know you and provide you with comprehensive care, we would appreciate your cooperation in completing both sides of this form in regards to your health. Please complete by checking the appropriate box. If further explanation is necessary, please add comments where appropriate. When you meet with the clinician you may be asked for some detail regarding your responses to clarify issues. Thank you for your time and effort.

GENERAL INFORMATION:

NAME:_____ AGE:_____ MALE / FEMALE DATE:_____

HOW DID YOU HEAR OF OUR PRACTICE?_____

OTHER MEMBERS OF YOUR HOUSEHOLD:

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		

REASON FOR YOUR VISIT TODAY:_____

ALLERGIES TO MEDICATIONS:_____

MEDICATIONS YOU TAKE CURRENTLY:

NAME	DOSE (MG)	# TIMES PER DAY	NAME	DOSE(MG)	# TIMES PER DAY

PAST MEDICAL HISTORY: Check the box if you have had any of the following. Otherwise leave blank.

- ☐ Heart attack
- ☐ High Blood Pressure
- ☐ Angina
- ☐ Stroke
- ☐ High Cholesterol
- ☐ High Triglycerides
- ☐ Blood Clots in Legs/lungs
- ☐ Asthma
- ☐ Emphysema
- ☐ Lung Problem
- ☐ Pneumonia
- ☐ Stomach Ulcer
- ☐ Crohn's/Ulcerative Colitis
- ☐ Kidney Problem
- ☐ Arthritis
- ☐ Back/neck injury
- ☐ Chronic Pain
- ☐ Diabetes
- ☐ Thyroid disease
- ☐ Head Injury
- ☐ Epilepsy
- ☐ Migraine Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Suicide Attempt
- ☐ Other Mental Illness
- ☐ Glaucoma
- ☐ Cancer: Type_____
- ☐ Other:_____

PAST SURGICAL HISTORY: Check the box and fill in the approximate date if you have had any of the following surgeries.

- ☐ Appendix _____
- ☐ Hips _____
- ☐ Knees _____
- ☐ Ankles _____
- ☐ Shoulders _____
- ☐ Heart _____
- ☐ Gall Bladder _____
- ☐ C-section _____
- ☐ Cervix _____
- ☐ Hernia _____
- ☐ Uterus _____
- ☐ Tonsils/Adenoids_____
- ☐ Tubal Ligation _____
- ☐ Vasectomy _____
- ☐ Skin Surgery _____
- ☐ Other:_____

FAMILY HISTORY:

FATHER is **living** at _____ years old. Health Problems:_____

Deceased at _____years old. Cause of Death:_____

Health problems on father's side of family:_____

MOTHER is **living** at _____ years old. Health Problems:_____

Deceased at _____years old. Cause of Death:_____

Health problems on mother's side of family:_____

BROTHERS: How many?_____ Any medical problems:_____

SISTERS: How many?_____Any medical problems:_____

SONS: How many?_____Any medical problems:_____

DAUGHTERS: How many?_____Any medical problems:_____

SOCIAL HISTORY

WHERE DO YOU WORK?_____ WHAT IS YOUR JOB TITLE?_____

HOBBIES/SPORTS/SPECIAL INTERESTS:_____

EXERCISE: YES / NO IF YES, WHAT KIND OF EXERCISE: _____ # OF DAYS PER WEEK:_____

DO YOU USE TOBACCO? YES / NO IF YES, HOW MUCH? ½, 1, 2, 3 PACKS PER DAY FOR HOW MANY YEARS?_____

DO YOU CONSUME ALCOHOL? YES / NO IF YES, WINE, BEER, HARD LIQUOR? HOW MUCH?_____ HOW OFTEN?_____

ANY HISTORY OF STREET DRUG USE? YES / NO IF YES, WHAT DRUG AND LAST TIME USED?_____

PREVENTATIVE HEALTH MAINTENANCE EXAMS

To the best of your knowledge, please provide the date with which you last had each of the following exams:

- Complete Physical Exam _____
- Pap Smear _____
- Breast Exam _____
- Mammogram _____
- EKG (heart tracing) _____
- Chest X-Ray _____
- TB Test _____
- Cholesterol Check _____
- Test for blood in stool _____
- Colonoscopy/Sigmoidoscopy _____
- Prostate Exam _____
- Testicular Exam _____
- PSA (prostate specific antigen) _____
- Skin Exam _____
- DEXA (bone density) _____

IMMUNIZATIONS

To the best of your knowledge, please provide the date with which you last had each of the following vaccinations:

- Pneumonia _____
- Flu _____
- Tetanus/Diphtheria _____
- Whooping cough (Pertussis) _____
- Polio _____
- Hepatitis A _____
- Hepatitis B _____
- Haemophilus Influenza B _____
- Typhoid _____
- Measles/Mumps/Rubella _____
- Shingles _____
- HPV _____

Thank you very much for your time and effort in completing your medical record. Please sign and date below.

PATIENT'S SIGNATURE:_____ DATE COMPLETED:_____

PHYSICIAN'S SIGNATURE:_____ DATE REVIEWED:_____